

JAN 10 1938

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

43566

Do not use this space.

1. PLACE OF DEATH

(a) County.....
(b) Township.....
(c) City St. Louis

Registration District No. 791
Primary Registration District No. 1003

Registered No. 11816

(d) Street No. City Hospital No. 1
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

John Wagoner
(a) Residence, No. 2331 a Pine St. 21
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male
4. COLOR OR RACE white
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb 22, 1886

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
51 9 29

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc. nil
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation 26 1/2

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Illinois

13. NAME Don't Know
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Don't Know 21

15. MAIDEN NAME Don't Know
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Don't Know 31

17. INFORMANT Hosp. Info M. Kent
(ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL
PLACE Calvary DATE 12/24, 1937

19. FUNERAL DIRECTOR (ADDRESS) J. H. Gebken
2342 Wisconsin

20. DEC 23 1937, 1937
J. Bredeck
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12/ 21/37, 1937

22. I HEREBY CERTIFY That I attended deceased from 12/19/37 to 12/21/37, 1937
I last saw him alive on 12/21/37, 1937. Death is said to have occurred on the date stated above, at 5.15 m. p.
The principal cause of death and related causes of importance were as follows:

Acute bacterial endocarditis
Rheumatic heart disease
Other contributory causes of importance: 95

Name of operation..... Date of.....
What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide?..... Date of injury....., 19.....
Where did injury occur?..... (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....
Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....
If so, specify.....
(Signed) Wm. Mederal I. M. D.
(Address) City Hospital No. 1.

STATEMENT BY LICENSED EMBALMER

I, _____, Licensed Embalmer No. _____
hereby certify that the body recorded on the reverse side of this certificate was embalmed by _____
_____ L. E. _____
No. _____ or by _____, Registered Apprentice No. _____
working under my personal supervision.

Signed _____

Licensed Embalmer No. _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

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